

2. Banking details for your monthly contributions

What you must do

Submit the following with this form: A copy of your ID and a bank statement/letter of confirmation from the bank.

These details apply when you pay directly towards your total contribution. Please note that we cannot accept credit card details. You can only use a South African bank account. The first deduction will take place at the beginning of the month following the start date as a retiree member.

Bank name Branch name
Account type Current Transmission Savings Branch code - -
Name of account holder
Account number
Signature of account holder

I _____, hereby give Discovery Health (Pty) Ltd and/or Anglovaal Group Medical Scheme permission to charge my bank account for my contributions to Anglovaal Group Medical Scheme.

3. Banking details for reimbursement of your claims

What you must do

Submit the following with this form: A copy of your ID and a bank statement/letter of confirmation from the bank.

Same as above? Yes No (if "No", please complete below)

Bank name Branch name
Account type Current Transmission Savings Branch code - -
Name of account holder
Account number
Signature of account holder

4. Your legal declaration

It is my sole responsibility as a member to make sure Anglovaal Group Medical Scheme receives the monthly premium. If contributions are outstanding for two months in a row, my membership will be cancelled in the third month. Short payment or non-payment of any of my contributions will result in suspension of my claims.

I confirm the content of this application is true and complete.

I agree to advise Anglovaal Group Medical Scheme in writing of any change in details that may occur between the date of this application form and the activation of my membership with Anglovaal Group Medical Scheme.

Signed at on Y Y Y Y M M D D

Signature of applicant Please do not sign an incomplete application form

5. Your employment details

If your employer is paying your full contribution or a part of it, please complete this section:

Name of employer Employer/billing number
Employee number Date of employment Y Y Y Y M M D D
1. Employer contact person 2. Employer contact person
Telephone Telephone
Email Email
Branch name Branch number - -
Department name Department number
Date of promotion (if applicable) Y Y Y Y M M D D

Please ensure your employer completes this warranty.

5. Your employment details *(continued)*

Employer warranty

1. We warrant that the main applicant detailed in section 1 is an employee of our organisation.
2. The Scheme may bill us for the amount due for this member in the same way as it does for our other employees with the Scheme.

Authorised signatory 1.	<input type="text"/>	Authorised signatory 2.	<input type="text"/>
Name/s	<input type="text"/>	Name/s	<input type="text"/>
Designation	<input type="text"/>	Designation	<input type="text"/>